IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 7, 2008

Rene Stephens
Campus View Home
875 Monroe
Twin Falls, Idaho 83301

Provider #13G070

Dear Ms. Stephens:

On June 26, 2008, a follow-up visit of your facility was conducted to verify corrections of deficiencies noted during the survey of May 15, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 20, 2008**, and keep a copy for your records.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 20, 2008. If a request for informal dispute resolution is received after July 20, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please feel free to call us at 334-6626.

Sincerely,

Sherri Cure for

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

Nicole,

Here is the rough draft for correction to the follow up for Campus View Home. I will make sure René has this information to get a finalized POC to you.

Thank you,
Becky

W-tag # W227:
Individual #1's file has been updated to include a diagnosis for anxiety and corresponding; WIC, HRC approval, IPP goals, and specific objectives that have been aligned to address the diagnosed issue.
Additional reviews of individuals' files to resolve inconsistent practices; application of specific objectives associated with identified diagnosis and treatment.
Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct.
QMRPs and/or QAM will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices.
Date of correction: 8/22/08

****

W-tag # W234:
Individual #1's file and program materials have been updated to include corrected WIC, HRC consent, and programming to address specific behavioral concerns. Individual #1 Physician's Order has been corrected to reflect accurate diagnostic condition, and corresponding programming to address identified diagnosis.
Additional reviews of individuals' files to resolve inconsistent practices; application of specific programming and corresponding training associated with identified diagnosis and treatment.
Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct.
QMRPs and/or QAM will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices.
Date of correction: 8/22/08

****

W-tag # W312:
Individual #1's current Physician's Order reflects accurate diagnosis. Files have been updated to reflect accurate behavioral recording methods associated with corrected diagnosis. Individual #1's Medication Reduction Plan has been corrected to accurately reflect identified behaviors and objectives. Individual #2's PRN Ambien has been added to the Medication Reduction Plan and has corresponding treatment objectives associated with a treatment objective.
Additional reviews of individuals' files to resolve inconsistent practices; application of specific programming and corresponding training associated with identified diagnosis and treatment.
Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct.
QMRPs, Nursing staff, and/or QAM will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices.
Date of correction: 8/22/08

****

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey. The surveyors conducting the survey were: Monica Williams, QMRP, Team Leader Sherri Case, LSW, QMRP Common abbreviations used in this report are: IPP - Individual Program Plan PRN - As Needed QAM - Quality Assurance Manager QMRP - Qualified Mental Retardation Professional WIC - Written Informed Consent	{W 000}		
{W 227}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the IPP included objectives to meet the needs for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of program plans designed to address the needs of an individual in areas most likely to impact his life. The findings include: Individual #1's IPP, dated 3/6/08, documented a 42 year old male diagnosed with mild mental retardation, major depression, and blindness. a. Individual #1's WIC for Buspirone (an anxiolytic	{W 227}	RECEIVED AUG 04 2008 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: René Stephens | TITLE: Administrator | (X6) DATE: 7/23/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 227}	Continued From page 1 drug), dated 8/7/07, documented the behavior modifying drug was related to throwing things and violence towards his family. However, his IPP contained no objectives related to throwing things or violence towards his family. When asked during an interview, on 6/26/08 at 12:45. p.m., if there were objectives for the behaviors, the QAM stated there were not. b. Individual #1's Physician Order, dated 5/15/08, documented he received Paxil (an antidepressant drug) 20 mg every morning for depression. The QAM stated during an interview, on 6/26/08 at 1:00 p.m., behaviors displayed for depression included refusing to participate in programs, refusing to eat and reclusion to his room. When asked if there were objectives to address Individual #1's refusals or reclusion to his room, she stated there were not. The facility failed to ensure Individual #1's IPP contained specific objectives to meet his behavioral needs.	{W 227}	W227: Individual #1's file has been updated to include a diagnosis for anxiety and corresponding; Written Informed Consent, Human Rights Committee approval, IPP goals, and specific objectives that have been aligned to address the diagnosed issue. Additional reviews of individuals' files to resolve inconsistent practices; application of specific objectives associated with identified diagnosis and treatment. Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct. QMRPs and/or Quality Assurance Manager will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices. Date of correction: 8/22/08 Responsible: QMRP and Quality Assurance Manager	
{W 234}	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of instructions to staff being included in an individual's programs. The findings include:	{W 234}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 234}	Continued From page 2 Individual #1's IPP, dated 3/6/08, documented a 42 year old male diagnosed with mild mental retardation, major depression, and blindness. a. Individual #1's record included a WIC, dated 8/7/07, which documented he received Buspirone for "behavior abnormalities" which included throwing things and violence towards his family. However, his record contained no program related to throwing things or violence towards his family. When asked during an interview, on 6/26/08 at 12:45 p.m., if there were written training programs for the maladaptive behaviors, the QAM stated there were not. b. Individual #1's Physician Order, dated 5/15/08, documented he received Paxil (an antidepressant drug) 20 mg every morning for depression. The QAM stated during an interview, on 6/26/08 at 1:00 p.m., behaviors displayed for depression included refusing to participate in programs, refusing to eat and reclusion to his room. Individual #1's IPP did not contain program plans that identified what staff were to do when he refused to eat, refused to participate in programs or isolated in his room. The QAM stated there were no program plans to address the behaviors. The facility failed to ensure written training program plans related to his maladaptive behaviors were developed for Individual #1.	{W 234}	W234: Individual #1's file and program materials have been updated to include corrected Written Informed Consent, Human Rights Committee consent, and programming to address specific behavioral concerns. Individual #1 Physician's Order has been corrected to reflect accurate diagnostic condition, and corresponding programming to address identified diagnosis. Additional reviews of individuals' files to resolve inconsistent practices; application of specific programming and corresponding training associated with identified diagnosis and treatment. Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct. QMRP and/or Quality Assurance Manager will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices. Date of correction: 8/22/08 Responsible: QMRP and Quality Assurance Manager	
{W 312}	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	{W 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 312}	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPP that were directed specifically towards the reduction of and eventual elimination of the behavior for which the drugs were used for 2 of 2 individuals (Individuals #1 and #2) whose behavior modifying drugs were reviewed. This resulted in individuals receiving behavior modifying drugs without appropriate plans that identified drug usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's IPP, dated 3/6/08, documented a 42 year old male diagnosed with mild mental retardation, major depression, and blindness. a. Individual #1's Physician Orders, dated 5/28/08, stated he received Buspirone (an anxiolytic drug) 15 mg twice a day for impulse control and anger management. Individual #1's Medication Reduction Plan, dated 6/08, stated he received Buspirone 15 mg twice a day for anxiety. The signs and symptoms section of the plan stated Buspirone was related to Individual #1's refusing to participate in programs, vomiting, verbal agression, and reclusion to his room. The "Medication Reduction Plan Objective" section stated "Buspar will be reduced when there are no events of vomiting (illness excluded) for 6 months." When asked during an interview on 6/26/08 at 1:00 p.m., if the behavioral criteria was correct for reducing Buspirone, the QAM stated Individual #1 did not have a behavior of vomiting and the Medication Reduction Plan needed to be	{W 312}	W312: Individual #1's current Physician's Order reflects accurate diagnosis. Files have been updated to reflect accurate behavioral recording methods associated with corrected diagnosis. Individual #1's Medication Reduction Plan has been corrected to accurately reflect identified behaviors and objectives. Individual #2's PRN Ambien has been added to the Medication Reduction Plan and has corresponding treatment objectives associated with a treatment objective. Additional reviews of individuals' files to resolve inconsistent practices; application of specific programming and corresponding training associated with identified diagnosis and treatment. Continued systematic review of individual's files at least quarterly (if not sooner) to determine that documentation is correct. QMRP, Nursing staff, and/or Quality Assurance Manager will review the client files at least quarterly (if not sooner) to identify and correct inconsistent practices. Date of correction: 8/22/08 Responsible: QMRP and Quality Assurance Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 312}	Continued From page 4 revised. b. Individual #1's Medication Reduction Plan, dated 6/08, stated he received Paxil (an antidepressant) 20 mg each morning for depression. The signs and symptoms section of the plan stated that Paxil was related to Individual #1's refusing to participate in programming, refusing to eat, and reclusion to room. The "Medication Reduction Plan Objective" section stated "Paxil will be reduced when the number of times reclusion to room has been decreased to 50% of the established baseline." When asked about the reduction criteria, on 6/26/08 at 1:00 p.m., the QAM stated the Medication Reduction Plan was inaccurate and needed to be revised. The facility failed to ensure #1's Medication Reduction Plans were adequately developed. 2. Individual #2 was a 45 year old male diagnosed with severe mental retardation, cerebral palsy, seizure disorder, expressive asphasia, chronic pain, and chronic peptic ulcer disease. He used a wheelchair for mobility purposes. Individual #2's Medication Reduction Plan, updated 6/5/08, stated he received Ambien 5 mg PRN which would be reduced based upon the following criteria: "[Individual #2] will self report and [sic] sleep difficulties and request the PRN." Individual #2's Medication Reduction Plan did not contain objective criteria. When asked about the criteria, the QMRP stated on 6/25/08 at 1:37 p.m., Individual #2 had an objective related to sleep but it was not in his Medication Reduction Plan. The QMRP stated the Medication Reduction Plan needed to be revised.	{W 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 312}	Continued From page 5 The facility failed to ensure an appropriate drug reduction plan related to the use of Ambien PRN was developed for Individual #2.	{W 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	R 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{MM197}	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	{MM197}	MM197 – see response W312	
{MM729}	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	{MM729}	MM729 - response for W227	
{MM855}	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	{MM855}	MM855 - response for W234	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rene Stephens TITLE Administrator (X6) DATE 7/23/08